King County Deputy Sheriff PacifiCare Medical/Vision Plan

Finalized April 9, 1999
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Directory

If you have questions about ...	Contact …
• Eligibility • Completing the enrollment form • King County Deputy Sheriff benefit program	Employee Benefits and Well-Being at (206) 684-1556 Monday - Wednesday between 8:30 a.m. and 4:30 p.m. Thursday between 10:30 a.m. and 4:30 p.m. Friday between 8:30 a.m. and 4:30 p.m. King County employee intranet (through the King County computer system) at http://ohrm/metrokc.gov/benefits
• Details about plan benefits (such as covered expenses, limitations, exclusions) • Network providers • Primary care providers • Changing your primary care provider • Out-of-area coverage • Specific medical conditions or treatment • Filing claims • Obtaining preauthorization (for care other than mental health or chemical dependency treatment)	PacifiCare at (800) 932-3004 Monday - Friday between 7:00 a.m. and 6:30 p.m. Pacific time
• Vista Optical providers	PacifiCare at (800) 932-3004 Monday - Friday between 7:00 a.m. and 6:30 p.m. Pacific time
• General information about PacifiCare (King County-specific information on benefits is not available on the PacifiCare website) • Network provider list for all participants (including King County Employees)	PacifiCare web site at www.pacificare.com
• Obtaining preauthorization for mental health and chemical dependency treatment	PacifiCare Behavioral Health at (800) 577-7244, 24 hours a day, 7 days a week or Making Life Easier toll-free at (888) 874-7290 24 hours a day, 7 days a week
• Registering for PacifiCare's Stop Smoking Program	PacifiCare's Health Improvement Line at (800) 513-5131

The information in this booklet is available in accessible formats by calling Employee Benefits at (206) 684-1556 (voice) or (206) 296-8535 (TDD), or through Washington State Telecommunication Relay Service at (800) 833-6388 (TDD).

HOW TO USE THIS BOOKLET

This booklet describes the medical coverage available to you and your family members under the PacifiCare Medical Plan if you are an eligible King County Deputy Sheriff employee. It summarizes the benefits, describes when coverage begins and explains how to use the plan. See your enrollment materials for details on enrollment procedures and deadlines, coverage options and related cost information.

Shaded areas throughout the booklet highlight key points for your convenience.

This booklet uses a number of technical terms you will need to know to understand your benefits. For your reference, we've defined many terms in "Definitions" starting on page 29.

Keep this booklet and refer to it whenever you have a question about your PacifiCare medical coverage. If you still have questions, contact the plan at the phone number or web site listed in the Directory in the front of this booklet. You may also call Employee Benefits and Well-Being at (206) 684-1556.

Although this booklet includes certain key features and brief summaries of this medical coverage, it does not provide detailed descriptions. If you have questions about specific plan details, contact the plan or Employee Benefits and Well-Being.

We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between this booklet and the insurance contracts or other legal documents, the legal documents will always govern.

King County intends to continue this plan indefinitely but reserves the right to amend or terminate it at any time, for any reason, according to the amendment procedures described in the legal documents.

This booklet does not create a contract of employment with King County.

LEARN MORE ABOUT … ON PAGE …

Visit the King County employee intranet (accessible only through the King County computer system) at http://ohrm/metrokc.gov/benefits

Visit the PacifiCare web site at www.pacificare.com for general information about PacifiCare. Note: For King County-specific benefit information (for example, covered expenses), consult this booklet.

LEARN MORE ABOUT (cont'd)… ON PAGE …

HIGHLIGHTS

Medical coverage offers financial protection for you and your family members in the event of illness or injury.

To receive benefits from the PacifiCare Medical Plan:

- You make an appointment with your primary care provider
- You pay any required copay when you receive health care services
- Your primary care provider will obtain preauthorization for your care as necessary
- The plan pays 100% for most covered services
- The plan handles all forms and paperwork.

WHO'S ELIGIBLE

Employees

You are eligible for medical coverage if you are:

- A represented, commissioned employee in a regular, active, year-round position and scheduled to work at least 35 hours each week, or
- A represented, commissioned employee in a regular, active, year-round position and scheduled to work under 35 hours each week — if your position has at least 10 pay periods of uninterrupted service a year with 5 full-time work days or the equivalent of 35 hours a pay period.

Retirees

Retirees are not eligible for this plan.

Family Members

A child is your natural child, adopted child, stepchild, legally placed foster child, legally designated ward, child placed with you as legal guardian, child legally placed with you for adoption, or a child for whom you assume total or partial legal obligation for support in anticipation of adoption.

The following family members are eligible for medical coverage:

- Your spouse or domestic partner named on the Affidavit of Marriage/Domestic Partnership on file with Employee Benefits and Well-Being.
- Unmarried children of you, your spouse or declared domestic partner who are:
  - Under age 23 and chiefly dependent on you for support and maintenance (generally that means family members you claim on your federal income tax returns).
  - Incapacitated due to developmental or physical disability and chiefly dependent on you for support and maintenance. The child must have become incapacitated while covered by the plan and before age 23. You must submit proof of the child's disability for enrollment (and periodically thereafter).
  - Named in a Qualified Medical Child Support Order (QMCSO) as defined under federal law and authorized by the plan. See page 29 for details.

To continue an incapacitated child's coverage after age 23, contact Employee Benefits and Well-Being within 60 days of the child's 23rd birthday.

COST

The county pays the full monthly cost of coverage for you and your eligible family members under this plan.

When you receive medical care under the PacifiCare plan, you pay:

- Any required copays at the time of service
- Amounts in excess of the usual, customary and reasonable (UCR) rates (see page 29 for definition)
- Expenses for services or supplies not covered by this plan.

ENROLLING IN THE PLAN

Your eligibility date is the first day of the calendar month after 3 months of continuous service.

If you are a newly hired employee, you must submit a completed enrollment form to Employee Benefits and Well-Being within 30 days of your hire date. See your enrollment materials for details.

Making Changes

Each year during open enrollment, you may change your elections.

To add coverage during the plan year, notify Employee Benefits and Well-Being and submit a completed enrollment form within 60 days of the status change. Otherwise, you must wait until the next open enrollment period.

You may drop family members' coverage anytime during the year. You may add family members' coverage during the plan year if any of these changes in family status occurs:

- Birth or placement of a child with you for adoption
- Placement of a foster child
- Loss of your child's eligibility under another health plan
- Death of a family member
- Marriage or establishment of a domestic partnership
- Divorce or dissolution of a domestic partnership
- Significant change in your spouse's or domestic partner's coverage attributable to his or her employment.

Enrollment forms are available from and must be submitted to Employee Benefits and Well-Being. You'll need to file a revised enrollment form within 60 days if there is any change in your family's eligibility.

Any change you make must be consistent with the change in family status. Here are several examples:

- If you adopt a child, you may add coverage for that child (you may not add coverage for your other children at that time)
- If your child loses coverage under your spouse's coverage, you may add this child to the county's plan
- If you get married, you may enroll your new spouse and his or her eligible children.

WHEN COVERAGE BEGINS

If you join during open enrollment, coverage is in effect for the entire plan year (if you remain eligible). See your enrollment materials for details.

If you enroll during the year as a newly hired employee, your PacifiCare medical coverage begins on the first day of the calendar month after you complete 3 months of work. If your first day of employment is the first working day of the month for your position, that month applies to the waiting period. For example, if your first scheduled day of work is Saturday April 3 (because Thursday and Friday will be your regular days off), your coverage begins July 1. If your first day of employment is April 15, your coverage begins August 1. To be covered during these first 3 months, you must self-pay.

If enrolled by the deadline (described in "Making Changes" starting on page 3), coverage for your:

Coverage for your family members does not start until your coverage begins and you submit a completed enrollment form listing the family members you want to cover. If your dependents are not enrolled in this plan and have other coverage — and lose that other coverage — they may be able to enroll in this plan during the year. Contact Employee Benefits and Well-Being at (206) 684-1556 for more information.

- Newborn or newly placed adopted child is retroactive to the date of birth or placement
- New spouse begins the first day of the calendar month after you're married
- Domestic partner begins the first day of the calendar month after the date you establish a domestic partnership as indicated on the Affidavit of Marriage/Domestic Partnership.

According to Washington State law, coverage is provided for newborns under the mother's coverage for the first 3 weeks of life. To continue the newborn's coverage after 3 weeks, the newborn must be eligible and enrolled by the deadline described in "Making Changes" on page 3.

PREEXISTING CONDITIONS

With the exception of transplants, there is no preexisting condition limit under this plan. See page 29 for more on the transplant waiting period.

HOW THE PACIFICARE MEDICAL PLAN WORKS

Medical Plan Summary

The following table summarizes covered services and supplies under the PacifiCare Medical Plan and identifies related coinsurance, copays, maximums and limitations. Please see "Covered Expenses" and "Expenses Not Covered" for more information on your medical benefits.

	PacifiCare Medical Plan	For More Information Refer To…
Annual deductible	None	—
Annual out-of-pocket maximum	$500/person; $1,500/family	Page 8
Lifetime maximum	None (except for chemical dependency and transplants)	Page 29
Covered Expenses	**Plan Pays**	
Additional benefits for LEOFF I employees	Not covered	Page 13
Alternative care	100%, after $5 copay/visit	Page 13
Ambulance services	100%	Page 14
Chemical dependency treatment (up to $5,000 in plan payments in 24 months; $10,000 lifetime maximum)	Inpatient: 100% Outpatient: 100%	Page 14
Chiropractic care (you must see a network provider❶)	Referred by PCP: 100%, after $5 copay/visit; Self-referred: 100%, after $10 copay/visit, up to 33 visits per year	Page 15
Diabetes care training	100%	Page 15
Durable medical equipment, prosthetics, orthopedic appliances	100%	Page 15
Emergency care (in an emergency room)	100%, after $50 copay/visit (waived if admitted)	Page 16
Family planning	100%	Page 17
Growth Hormones	Not covered	Page 17
Home health care❷ (up to 130 visits/year)	100%	Page 17
Hospice care❷ (6 months lifetime maximum)	100%	Page 18
Hospital care (inpatient and outpatient)	100%	Page 19
Infertility	Not covered	Page 20
Injury to teeth	100%	Page 20
Inpatient care alternatives	100%	Page 21
Lab, x-rays and other diagnostic testing (includes mammograms, prenatal tests)	100%	Page 21

❶ Call PacifiCare for a list of network providers.

❷ Must be in place of a hospital stay.

Medical Plan Summary (cont'd)

Covered Expenses	Plan Pays	For More Information Refer To…
Manipulative therapy	See chiropractic care	Page 21
Maternity care	100%, after a $10 copay/pregnancy	Page 21
Mental health care – Inpatient (up to 30 days/year) – Residential and day treatment (also subject to inpatient maximum; each day of care counts as half an inpatient day) – Outpatient	 100% 100% 100%, after $5 copay/visit, up to 30 visits/year	Page 22
Neurodevelopmental therapy (age 6 and under) – Inpatient – Outpatient	 100% 100%, after $10 copay/visit, up to 60 visits/condition	Page 24
Newborn care (up to at least 3 weeks as mandated by state law)	Covered at various levels	Page 24
Physician and other medical and surgical services	Inpatient: 100%; Outpatient: 100%, after $5 copay/visit	Page 24
PKU formula	100%	Page 25
Prescription drugs – Mail order pharmacy (up to 90-day supply) – Network pharmacies (up to 30-day supply) • Generic drugs and insulin • Brand-name drugs (covered only when generic not available)	 100%, after $10 copay/prescription or refill 100%, after $5 copay/prescription or refill	Page 25
Preventive care	100%, after $5 copay/visit	Page 28
Radiation therapy, chemotherapy and respiratory therapy	100%	Page 29
Reconstructive services	100%	Page 29
Rehabilitative services – Inpatient – Outpatient	 100% 100%, after $10 copay/visit, up to 60 visits/condition	Page 29
Skilled nursing facility❷	100%, up to 150 days lifetime maximum/condition	Page 29
Smoking cessation	100%, after $20 copay for the program	Page 29
Sterilization procedures	See family planning	Page 29

❷ Must be in place of a hospital stay.

Covered Expenses	Plan Pays	For More Information Refer To…
Supplemental accident benefits	Not covered	Page 29
TMJ	Not covered	Page 29
Transplants (certain transplants only; up to $500,000 lifetime maximum)	100%	Page 29
Urgent care	100%, after $5 copay/visit	Page 29
Vision care – Eye exams, routine	100% for 1 exam/calendar year	Page 29

How the Plan Pays Benefits

You receive plan benefits (usually paid at 100%) when your care is provided or coordinated by your primary care provider. Depending on the service, a copay may be required at the time of service.

Annual Deductible

There is no annual deductible under the PacifiCare Medical Plan (unless you live outside the service area; see page 12 for details).

Annual Out-of-Pocket Maximum

The out-of-pocket maximum is the most you pay in coinsurance for covered expenses each year. This means once you've reached your out-of-pocket maximum, the plan pays 100% for most covered expenses for the rest of that year.

Your annual out-of-pocket maximum is $500/person; $1,500/family. The following don't apply to the out-of-pocket maximum:

- Prescription drug copays
- Chiropractic care copays
- Mental health care copays
- Emergency room copays
- Amounts in excess of UCR rates (see page 29)
- Charges beyond benefit maximums
- Expenses not covered under the plan.

Lifetime Maximum

There is no lifetime maximum under the PacifiCare Medical Plan (except for chemical dependency and transplants).

The Network

All providers — hospitals, clinics, doctors and other health care professionals who make up the PacifiCare network — are carefully screened by PacifiCare.

To be considered for the network, all hospitals must be accredited by the Joint Commission on Accreditation of Health Care Organizations and have a current state license as well as adequate liability insurance. Doctors or other health care professionals must also complete a detailed application to be considered for the network. The application covers education, status of board certification, malpractice and state sanction histories.

Selecting a Primary Care Provider (PCP)

Your primary care provider is your personal doctor and the starting point for all your medical care.

Primary care providers can be family or general practitioners, internists or pediatricians. If you need a specialist, your primary care provider will arrange it. To receive benefits, your primary care provider must provide or coordinate all of your care.

Each family member may have a different primary care provider.

You must select a primary care provider when you enroll; otherwise one will be chosen for you. Refer to the PacifiCare provider directory for a list of primary care providers. The directory is updated periodically; for a current list, contact PacifiCare. The name of your primary care provider will be printed on your identification card.

Continuity of your care is important — and easier to achieve if you establish a long-term relationship with your primary care provider. However, you may find it necessary to change providers. Before you see another primary care provider, you must call PacifiCare at (800) 932-3004. You may see your new primary care provider the first of the month following PacifiCare's approval of your request.

Primary Hospital

When you choose a primary care provider, you are also choosing the hospital for most hospital services you need (called a "primary hospital"). Your PacifiCare provider directory includes the hospital with which each provider is affiliated.

Specialists

Specialist benefits are payable only if the referral is authorized by your primary care provider before you see the specialist.

To receive benefits, you must obtain a referral from your primary care provider before you see a specialist. Your primary care provider has agreed to refer you only to specialists who are:

- Licensed, certified or registered, as required by the state.
- Affiliated with your primary care provider's medical group. (Most belong to large medical groups of multiple specialty providers and facilities.)
- Affiliated with your primary hospital. You are responsible for confirming (by calling PacifiCare) that you're being referred to a specialist affiliated with your primary hospital.

If you have an unusual medical condition, you may need to see a specialist who is not affiliated with your primary hospital or medical group.

Expired referrals must be renewed by the primary care provider if additional specialist care is required.

Be sure to get a referral form from your primary care provider and take it to the specialist. The referral will state the number of visits and/or type of treatment.

If a specialist wants you to see another specialist, you must check with your primary care provider, who will determine if the second referral is medically necessary. Centralizing care through your primary care provider avoids duplicated or conflicting treatment.

Accessing Care

To receive benefits from the PacifiCare Medical Plan:

- You make an appointment with your primary care provider
- You pay any required copay when you receive health care services
- Your primary care provider will obtain preauthorization for your care as necessary
- The plan pays 100% for most covered services
- The plan handles all forms and paperwork.

You may see any provider in an emergency.

For some benefits, you may receive services from a *network provider* — without a referral from your primary care provider:

- Chiropractic care (maximum 33 visits a year without a referral; no maximum with a referral)
- Chemical dependency treatment (must be preauthorized by PacifiCare Behavioral Health)
- Mental health care (must be preauthorized by PacifiCare Behavioral Health)
- Urgent care
- Women's health care services, such as maternity care, reproductive health services and gynecological care.

Call PacifiCare for information on network providers. Depending on the service, you may need to obtain preauthorization for your care; see "Obtaining Preauthorization" below for details.

Second Opinions

To receive benefits for a second opinion, you must have a referral from your primary care provider.

Obtaining Preauthorization

You must obtain preauthorization if you don't see your primary care provider for these services:

- Chemical dependency treatment
- Mental health care
- Women's health care services involving hospitalization or surgery.

You do not need preauthorization for:

- Accidents
- Emergencies (including detoxification).

However, you (or a family member or hospital staff member) are expected to call PacifiCare or your primary care provider within 24 hours from the start of your care (48 hours for mental health care or chemical dependency treatment).

Obtaining Preauthorization (cont'd)

How to Call

To obtain preauthorization for other than mental health care and chemical dependency treatment, have your provider call PacifiCare at (800) 932-3004, 7:00 a.m. to 6:30 p.m. Pacific time, Monday - Friday.

To obtain preauthorization for *mental health care* and *chemical dependency treatment*, you or your provider must call PacifiCare Behavioral Health at (800) 577-7244, 24 hours a day, 7 days a week.

When you call PacifiCare, be prepared to give them:

- Your name
- Group number and member number (on your identification card)
- The reason for your call.

If You Don't Call

If you do not obtain preauthorization as described above, your care will not be covered.

If You Live Outside the Service Area

Call PacifiCare for information on service areas.

You are eligible for out-of-area benefits if you live outside PacifiCare Medical Plan's service area *and* more than 30 miles away from the nearest available primary care provider for at least 9 months out of each year.

Here's how the out-of-area plan works:

Also see "If Your Family Member Lives Away From Home" on page 29 for related information.

- You pay a $200/person, $600/family annual deductible. (The deductible doesn't apply to prescription drugs.)
- You make an appointment with a licensed provider.
- The plan pays 80% for most covered services. If you reach a $1,000/person ($2,000/family) out-of-pocket maximum, the plan pays 100% for most covered expenses for the rest of that year.
- You must obtain preauthorization for certain procedures and services, as described on page 11.

- Depending on your provider, you may have to pay the bill in full and file a claim for reimbursement.
- You are responsible for any charges that exceed UCR rates (see page 29 for a definition).

All other terms and limitations of the PacifiCare Medical Plan described in this booklet apply to out-of-area benefits.

Mental Health Care and Chemical Dependency Treatment: Out-of-area participants do not need to see PacifiCare Behavioral Health providers for mental health care or chemical dependency treatment (but you or your provider will need to obtain preauthorization by calling PacifiCare Behavioral Health at (800) 577-7244).

Prescription Drugs: You don't need to fill your prescriptions at a network pharmacy to receive out-of-area benefits. Pay for the prescription in full and file a claim for a reimbursement. The plan pays 100% minus the copay (see "Medical Plan Summary" on page 5 for copay amounts).

COVERED EXPENSES

PacifiCare Medical Plan covers illness and injuries on and off the job for LEOFF I employees if the claim has been denied by Workers' Compensation. For all other employees, Workers' Compensation generally covers on-the-job injuries.

The following section describes expenses covered by the PacifiCare Medical Plan. For information on the level of benefits you receive, (for example, related coinsurance, copays, maximums and limitations) refer to "Medical Plan Summary" starting on page 5. Also see "Expenses Not Covered" starting on page 29.

To be covered, services and supplies must be medically necessary and prescribed or authorized by your primary care provider, unless otherwise noted.

Additional Benefits for LEOFF I Employees

LEOFF I refers to firefighters and law enforcement officers who are members of LEOFF Plan 1.

Additional benefits for LEOFF I employees are not available under the PacifiCare Medical Plan.

Alternative Care

Covered services include but are not limited to professional services of a:

- Licensed acupuncturist

- Licensed naturopath

Alternative Care (cont'd)

You must have a referral from your primary care provider to receive benefits for alternative care.

- Massage therapist, unless for recreational, sedative or palliative reasons; soft-tissue massage must be medically indicated.

This plan does not cover:

- Herbal preparations
- Nutritional supplements
- Teas.

Ambulance Services

Services of a licensed ambulance are covered to transport you to the nearest facility equipped to treat your condition, but only when other modes of travel would put you in danger.

Chemical Dependency Treatment

You may also receive these benefits through King County's Making Life Easier Program by calling toll-free (888) 874-7290. Staff will obtain preadmission approval as necessary and refer you to a provider for treatment.

The plan covers treatment of chemical dependency by an approved alcoholism or drug treatment facility (see page 29 for a definition). This includes:

- Inpatient care, including detoxification
- Residential or day treatment
- Outpatient care
- Individual and group therapy
- Family therapy for the patient and covered family members.

You don't need a referral from your primary care provider for chemical dependency treatment.

You must obtain preauthorization for your care from PacifiCare Behavioral Health or Making Life Easier as described in "Obtaining Preauthorization" (see page 11).

The plan does not cover:

- Volunteer support groups

- Confinements or procedures not preauthorized by Behavioral Health (even if referred by your primary care provider).

Chiropractic Care

You must see a network chiropractor for care; you do not need a primary care provider referral for up to 33 visits a year. Call PacifiCare for a current list of network chiropractors.

The plan covers services of licensed chiropractors, limited to:

- Full spinal x-rays
- Diagnostic laboratory services directly related to your spinal care treatment
- Noninvasive spinal manipulations.

Please see page 5, "Medical Plan Summary" for required copays.

Diabetes Care Training

The plan covers diabetic care training when prescribed by your primary care provider.

Durable Medical Equipment, Prosthetics, Orthopedic Appliances

Durable medical equipment and prosthetics are covered if they have a specific therapeutic purpose in treating your illness or injury and are:

- Prescribed by your provider
- Primarily and customarily used only for medical purposes
- Designed for prolonged use.

Covered items include:

- Artificial limbs or eyes (including implant lenses prescribed by a network provider and required as a result of cataract surgery or to replace a missing portion of the eye)
- Casts, splints, crutches, trusses or braces
- Diabetic equipment such as blood glucose monitor, diabetic shoes and inserts, and insulin pumps not

covered under the prescription benefit (excluding batteries) when ordered by a provider to treat diabetes

- Initial external prosthesis and bra necessitated by breast surgery and replacement of these items when required by normal wear, a change in medical condition or additional surgery

Durable Medical Equipment, Prosthetics, Orthopedic Appliances (cont'd)

- Ostomy supplies
- Oxygen and rental equipment for its administration
- Penile prosthesis when impotence is caused by a covered medical condition, a complication directly resulting from a covered surgery or an injury to the genitalia or spinal cord (and if other accepted treatment has been unsuccessful)
- Rental or purchase (approved by PacifiCare) of durable medical equipment such as wheelchairs, hospital beds and respiratory equipment (combined rental fees may not exceed full purchase price)
- Wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition.

Emergency Care

You do not need a referral from your primary care provider before receiving emergency care. See page 29 for instructions on what to do if you need emergency or urgent care.

An emergency is defined on page 29. Conditions that might require emergency care include, but are not limited to:

- Severe breathing problems
- Unconsciousness or confusion — especially after a head injury
- Bleeding that will not stop
- Major burns
- An apparent heart attack (chest pain, sweating, nausea)
- Convulsions.

Family Planning

Covered family planning expenses include:

- Vasectomy
- Tubal ligation
- Voluntary termination of pregnancy.

The plan does not cover:

- Infertility treatment, sterility or sexual dysfunction treatment or diagnostic testing
- Procedures to reverse voluntary sterilization
- Intrauterine birth control devices (IUDs).

Birth control drugs are covered under the prescription drug benefit described starting on page 25.

Growth Hormones

Growth hormones are not covered by this plan.

Home Health Care

You must have a referral from your primary care provider to receive home health care benefits.

Home health care services are covered if:

- Provided and billed by a licensed Washington state home health care agency
- Part of a home health care plan, and
- Care takes the place of a hospital stay.

Services and prescription drugs provided and billed by a home infusion therapy company are also covered if the company is licensed by the state as a home health agency.

Covered services include:

- Nursing care
- Physical therapy
- Occupational therapy
- Respiratory therapy

- Restorative therapy
- Restorative speech therapy
- Prescription drugs, if used during a period of covered home health agency care (prescription drugs included in a home health treatment plan will not require a copy).

Home Health Care (cont'd)

The following services are not covered:

- Custodial care, except by home health aides as ordered in the approved plan of treatment
- House cleaning
- Services of any social worker
- Services or supplies not included in the approved plan of treatment
- Services by a person who resides in your home or is a family member
- Travel costs or transportation services.

Hospice Care

You must have a primary care provider referral for hospice care.

Hospice care is a coordinated program of supportive care for a dying person by a team of professionals and volunteers. The team may include a provider, nurse, medical social worker or physical, speech, occupational or respiratory therapist.

Hospice care services are covered if:

- Provided and billed by an organization licensed as a hospice by Washington state
- Part of a hospice care treatment plan
- Care takes the place of a hospital stay.

Covered services include:

- Physician services
- Drugs and medications
- Emotional support services

- Home health services
- Homemaker services
- Inpatient hospice care
- Respite care for family members who care for the patient.

The following services are not covered:

- Bereavement or pastoral counseling
- Funeral arrangements
- Financial or legal counseling (examples are estate planning or the drafting of a will)
- Homemaker, caretaker or other services not solely related to you, such as:
  - Sitter or companion services for the person who is ill or other family members
  - Transportation
  - House cleaning or upkeep
  - More than 5 days of respite care in any 3-month period of hospice care
- Any services provided by members of your family.

Hospital Care

Inpatient

You must have a referral from your primary care provider to receive benefits for hospital services.

Covered inpatient hospital care includes:

- Newborn nursery care after covered childbirth, including circumcision
- Hospital services, such as operating rooms, recovery rooms, isolation rooms, cast rooms; anesthesia and related supplies administered by hospital staff; drugs; splints, casts and dressings; blood, blood plasma and blood derivatives; artificial kidney treatment; oxygen and its administration; x-ray, radium and radioactive isotope therapy; x-ray and lab exams, electrocardiograms, physiotherapy and hydrotherapy

- Intensive care or coronary care units
- Physician services
- Semiprivate room, meals, general nursing care (private room charges are covered only up to the hospital's semiprivate rate)
- Surgery and anesthesia administration.

Hospital Care (cont'd)

Outpatient

Covered outpatient hospital care includes:

- Diagnostic and therapeutic nuclear medicine in a hospital setting
- Hospital outpatient chemotherapy only for the treatment of malignancies
- Outpatient surgery
- Surgery in an ambulatory surgery center in place of inpatient hospital care.

Infertility

The plan does not cover:

- Infertility treatment, sterility or sexual dysfunction treatment or diagnostic testing
- Procedures to reverse voluntary sterilization.

Injury to Teeth

Accidental injury to mouth and natural teeth is covered but limited to stabilization services received within 6 months of the injury. Benefits for dental accidents cover a licensed dentist and a provider licensed as a denturist for services within the scope of that license, if those services would have been covered if performed by a dentist.

Inpatient Care Alternatives

You need a primary care provider referral to receive benefits for inpatient care alternatives.

Your physician may develop a written treatment plan for an equally or more cost-effective setting than a hospital or skilled nursing facility. All hospital or skilled nursing facility benefit terms, maximums and limitations apply to inpatient care alternatives.

Lab, X-rays and Other Diagnostic Testing

Covered services include:

You must have a referral from your primary care provider to receive these benefits.

- Lab or x-ray services, such as ultrasound, mammograms, nuclear medicine, allergy testing and administration of allergy serum (the serum itself is covered under "Physician and Other Medical and Surgical Services" on page 24)
- Screening and diagnostic procedures during pregnancy as well as related genetic counseling (when medically necessary for prenatal diagnosis of congenital disorders)

See "Preventive Care" on page 28 for more information on routine tests such as hearing tests.

- Medically necessary hearing tests by the physician or a licensed audiologist
- Services to diagnose or treat medical conditions of the eye by a provider licensed as an optometrist by Washington state; eyewear and routine vision exams and tests for vision sharpness are not covered under this benefit (see page 29 for covered vision services).

Manipulative Therapy

See "Chiropractic Care" on page 15.

Maternity Care

You may self-refer for women's health care services including maternity care. Inpatient hospital and outpatient surgery must be preauthorized.

Maternity care is covered if provided by a:

- Physician
- Registered nurse midwife
- Provider licensed as a midwife by Washington state.

Covered maternity care includes:

- Pregnancy care

- Screening and diagnostic procedures during pregnancy
- Related genetic counseling when medically necessary for diagnosing congenital disorders of the unborn child
- Hospitalization and delivery, including delivery at a licensed birthing center (see "Hospital Care" on page 19 for more information)

Maternity Care (cont'd)

While preauthorization is necessary for hospital admissions, you don't need to preauthorize the length of the stay.

- Complications of pregnancy or delivery
- Postpartum care

Benefits for any hospital length of stay due to childbirth for the mother or newborn cannot be limited to less than 48 hours for a vaginal delivery or less than 96 hours for a cesarean section. However, the health care provider, after consulting with the mother, may discharge the mother or newborn before the 48 or 96 hours.

The plan does not cover:

- Home pregnancy tests
- Maternity services for dependent children
- Planned deliveries in other settings, such as your home.

Mental Health Care

You must obtain preauthorization from PacifiCare Behavioral Health or Making Life Easier as described in "Obtaining Preauthorization" (see page 11).

Inpatient and outpatient mental health care is covered. The mental health care benefit is provided through an arrangement between PacifiCare of Washington and PacifiCare Behavioral Health. To be covered, mental health care must be performed by a hospital, physician (such as a psychiatrist, psychologist or registered nurse), residential treatment facilities, providers licensed or certified as required by the state to provide mental health counseling, community mental health agencies licensed by the state or state mental hospitals.

You may also receive these benefits through King County's Making Life Easier Program by calling toll-free (888) 874-7290. Staff will obtain preadmission approval as necessary and refer you to a provider for treatment.

You do not need a primary care provider referral for mental health care.

Covered services include the following, when medically necessary:

- Physical exams and intake history
- Individual and group psychotherapy
- Marriage and family therapy
- Psychological testing
- Laboratory services related to the covered provider's approved treatment plan.

The plan does not cover:

- Certain nonorganic therapies: bioenergetic therapy, confrontation therapy, crystal healing therapy, educational remediation, guided imagery, marathon therapy, primal therapy, rolfing, sensitivity training, training analysis, transcendental meditation, Z therapy or milieu therapy
- Certain organic therapies: aversion therapy (such as electric shock for behavioral modification), carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, L-tryptophan and vitamins, narcotherapy with LSD or sedative action electrostimulation therapy
- Conditions of or related to substance use/abuse (except as described in "Chemical Dependency Treatment" on page 14) or pathological gambling
- Long-term, insight-oriented psychotherapies designed to regress the patient emotionally or behaviorally
- Mental retardation care
- Personal enhancement or wellness development and related programs not considered medically necessary
- Private rooms or private duty nursing
- Spiritual counseling or dance, poetry, music or art therapy

- Surgery as a treatment for a mental disorder.

Without a psychiatric diagnosis of a mental condition, the plan also doesn't cover:

- Bereavement or catastrophic illness counseling
- Biofeedback
- Counseling related to adoption, custody, family planning or pregnancy
- Sex therapy or sexual addiction therapy.

Neurodevelopmental Therapy

You must have a referral from your primary care provider to receive neurodevelopmental therapy benefits.

The plan covers neurodevelopmental therapy for covered family members age 6 and younger, including:

- Hospital care
- Physician services
- Occupational, speech and physical therapy (if ordered and periodically reviewed by a physician)
- Maintenance of the patient when his/her condition would significantly worsen without those services
- Services to restore and improve function.

Newborn Care

The plan covers newborns under the mother's coverage for the first 3 weeks, as required by Washington state law.

To continue the newborn's coverage after 3 weeks, the newborn must be eligible and enrolled by the deadline described in "Making Changes" on page 3.

Physician and Other Medical and Surgical Services

The plan covers:

- Immunization agents or biological sera, such as allergy serum

- Medical care in the physician's or alternative provider's office
- Nutritional counseling by a registered nutritionist or dietitian when medically necessary for disease management
- Physician services for surgery, anesthesia, inpatient and emergency room visits
- Second opinions obtained before treatment (the provider giving the second opinion must be qualified, either through experience or specialist training).

PacifiCare also has the right to ask for a second opinion to confirm the medical necessity of a proposed surgery or treatment plan.

PKU Formula

The plan covers the medical dietary formula that treats phenylketonuria (PKU). You may order up to 5 cases in any month.

Prescription Drugs

To obtain covered prescription drugs, you may use the mail order program or network pharmacies. You may order up to a 90-day supply/prescription or refill under the mail order program or up to a 30-day supply from a network pharmacy.

Prescriptions from pharmacies other than the mail order or network pharmacies are covered only in an emergency or for out-of-area plan participants.

Covered Prescription Drugs

The following prescription drugs are covered:

- Prescription drugs (other than those listed in "Drugs Not Covered" on page 27) that can be dispensed only by written prescription of a physician or someone else authorized to prescribe that drug under applicable state law. Insulin is also covered.
- Compounded medication (other than those listed in "Drugs Not Covered" on page 27) made up of at least 1 prescription drug.
- Needles and syringes equal to the supply of covered self-administered injectable drugs dispensed. Glucose testing

strips, injection devices (when medically necessary) and lancets are also covered, up to a supply equaling the supply of covered insulin dispensed. (You pay a prescription drug copay for these supplies in addition to the copay for the related drug.)

- Glucagon emergency kits.
- Oral and injectable birth control prescription drugs.
- Devices and supplies that require a physician's prescription by law.

How to Use the Mail Order Pharmacy

The first time you use the mail order pharmacy, fill out the patient information questionnaire on your prescription drug order form (call PacifiCare for a form). This questionnaire only needs to be completed once. The information is maintained by the pharmacy and will assist the pharmacist in cross checking future medicines for drug allergies.

Each time you order, send the prescription drug order form with your payment directly to the mail order pharmacy's address on the form. You may include your physician's written prescription with your order form and payment or have your physician call in the prescription directly to the mail order pharmacy. The toll-free number is on the order form.

All prescriptions are processed promptly and are usually returned to you in 10 to 14 days. If you don't receive your medicine within 14 days or if you have questions about your medicine, call the mail order pharmacy.

How to Use the Network Pharmacies

An extensive network of pharmacies has agreed to dispense covered prescription drugs to PacifiCare Medical Plan participants at a discounted cost and not to bill you for any amounts over the copay. You may go to any network pharmacy (a referral from your primary care provider is not necessary).

Here's how it works:

- Choose a network pharmacy. (See your enrollment materials for a directory or call PacifiCare to find a pharmacy near you.)
- Show your identification card to the network pharmacist each time you want a prescription filled or refilled. (PacifiCare will issue an identification card for each participant; parents buying covered drugs for their children should show the identification card of the child who'll be taking the medicine.)
- Pay the copay for each covered prescription or refill.
- There are no claim forms to submit; the network pharmacy will bill the plan directly.

If you don't show your identification card and the network pharmacy cannot reach PacifiCare to confirm you're covered, no benefits will be provided.

The only exceptions are for:

- Emergencies
- Out-of-area plan participants
- Plan participants to whom an identification card has not yet been issued.

In these situations, you'll need to pay the pharmacy in full and submit the claim to PacifiCare.

Drugs Not Covered

The following prescription drugs and items are not covered:

- Appetite suppressants.
- Birth control devices, supplies or preparations that do not require a physician's prescription by law, even if you have a prescription. Birth control implants, such as Norplant, are not covered. This exclusion applies regardless of intended use.

- Drugs labeled "Caution — limited by federal law to investigational use" or experimental drugs. See page 29 for more information.
- Drugs prescribed by a provider not authorized by the state to prescribe the drugs or by a type of provider not covered under this plan. Drugs dispensed by a provider other than the mail order or network pharmacy also are not covered. (However, benefits may be available under other plan benefits, for example, hospital inpatient care.)
- Drugs used for cosmetic purposes.
- Growth hormone, regardless of intended use.
- Lifestyle drugs such as anti-obesity and anti-aging drugs.
- Nicotine-containing preparations in any form unless you're currently enrolled in the Stop Smoking Program and authorized for nicotine patches.

Prescription Drugs (cont'd)

- Nonprescription drugs, other than insulin or prescription drugs equivalent to nonprescription drugs.
- Prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy.
- Therapeutic devices and appliances, support garments or other nonmedical supplies.
- Vitamins.

Preventive Care

You don't need a primary care provider referral before seeing a network provider for women's health care services (maternity care, reproductive health services and gynecological care). However, depending on the service (for example, if you need surgery), you may need to obtain preauthorization; see page 11 for details.

The following preventive care is covered:

- Immunizations, including annual flu shots
- Routine tests, such as physicals, pap tests and hearing tests.

Mammograms are covered, but not under this preventive care benefit; see "Lab, X-rays and Other Diagnostic Testing" on page 21. Home cholesterol tests are not covered.

Preventive care benefits are payable according to the following schedule:

Birth to 1 year	Routine newborn care, plus 5 visits
1 - 5 years	4 visits/year
6 and older	1 visit/year

The following programs are also covered if arranged or provided by the PacifiCare Wellness Company. If you have questions, call the number listed.

Healthy Pregnancy Program

This program helps women care for themselves during pregnancy and learn how to care for their new babies. The program is designed to complement prenatal medical care. To enroll, call PacifiCare at (800) 932-3004.

Once you enroll, you'll receive 3 home mailings. The first will contain a book, videotape and brochures describing how to take care of yourself during pregnancy; the second has a videotape and brochures on infant care; the last mailing includes a book on infant safety, clothing and general infant care.

Exercise Program

Call PacifiCare at (800) 932-3004 to find out about participating health clubs and costs.

To encourage you to make a habit of regular exercise, PacifiCare offers preferred pricing for you and your covered family members at local area health clubs. Preferred pricing may vary from club to club.

Radiation Therapy, Chemotherapy and Respiratory Therapy

Inpatient and outpatient services are covered for medically necessary radiation, chemotherapy and respiratory therapy when prescribed by your primary care provider.

Reconstructive Services

The following reconstructive services are covered when preauthorized by PacifiCare:

- To correct a congenital anomaly or disease of a child as determined by the plan provider

- Treatment for an injury within 6 months after an accident giving rise to the injury, or as soon as medically feasible
- Reconstructive breast surgery and associated procedures following a medically necessary mastectomy (regardless of when the mastectomy was performed) and determined in consultation with the patient and attending physician, including:
  - Reconstruction of the breast on which the mastectomy has been performed
  - Surgery and reconstruction of the healthy breast to produce a symmetrical appearance
  - Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas
  - Reduction mammoplasty when established medical criteria are met
  - Removal of breast implants.

For information on the level of benefits you receive, refer to “Medical Plan Summary” starting on page 5.

Rehabilitative Services

Inpatient

Inpatient rehabilitative care is covered if:

- You receive the care in a hospital or Medicare-certified inpatient rehabilitative facility
- It is medically necessary to restore or improve normal body functions lost or impaired due to illness or injury
- Services could not be done in a less intensive setting and are ordered by a physician.

You must have a primary care provider referral to receive benefits for inpatient or outpatient rehabilitative care.

Covered services include physical, speech and occupational therapy as well as other services normally a part of inpatient rehabilitative care.

Outpatient

Outpatient rehabilitative care is covered if:

- Received from a provider licensed, registered or certified as required by the state to provide such services
- Medically necessary to restore or improve normal body functions lost or impaired due to illness or injury
- Ordered by a physician.

Covered services include physical, speech and occupational therapy.

The outpatient rehabilitative care benefit does not cover:

- Care to halt or slow further physical deterioration
- Self-help training (such as Outward Bound or recreational therapy)
- Evaluation and treatment of learning disabilities except as provided for neurodevelopmental therapy (see page 24)
- Social, vocational or cultural rehabilitation.

Skilled Nursing Facility

You need a referral from your primary care provider to receive skilled nursing facility benefits.

Skilled nursing facility services are covered if:

- Provided and billed by a licensed Washington skilled nursing facility
- The care takes the place of a hospital stay.

Prescription drugs are covered when provided by the skilled nursing facility and used by the patient during a period of covered skilled nursing facility care.

The following services are not covered:

- Services or supplies not included in the approved plan of treatment
- Services by a person who resides in your home or is a family member
- Travel costs
- Custodial care furnished in a skilled nursing facility or services not usually provided by a skilled nursing facility.

Skilled nursing facility confinement for developmental disabilities, mental conditions or primarily domiciliary, convalescent or custodial care is not covered.

Smoking Cessation

The Stop Smoking Program allows you to quit smoking at your own pace. Here's how it works:

You do not need a referral from your primary care provider to take advantage of this program.

- Call PacifiCare's Health Improvement Line at (800) 513-5131 to register.
- A kit containing a video, cassette and booklets will be mailed to your home. The kit will help you prepare for and set a date to stop smoking. It also helps you learn how to resist the smoking urge.
- Within a week after receiving your kit, a trained smoking cessation specialist will call you to go over the program. The specialist is an ex-smoker and can focus on your needs to help in the quitting process.

Smoking Cessation (cont'd)

- The specialist will continue to call you to provide support. You and the specialist agree on when and where the calls will be made to make sure the program works best for you.

You may also be eligible to receive nicotine patches. You will be screened for eligibility when you enroll in the Stop Smoking Program. If you qualify for nicotine replacement therapy, you pay a $20 copay for each 4-week supply of nicotine patches.

This benefit does not cover inpatient care or support group fees.

Sterilization Procedures

Sterilization procedures are covered as described under "Family Planning" on page 17.

Supplemental Accident Benefit

Supplemental accident benefits are not covered under the PacifiCare Medical Plan.

TMJ

Expenses related to temporomandibular joint (TMJ) disorders are not covered under the PacifiCare Medical Plan.

Transplants

You must have a primary care provider referral to receive transplant benefits.

The PacifiCare Medical Plan does not cover organ, bone marrow or stem cell transplants (except skin grafts) incurred during the first 12 consecutive months after your coverage begins. If you transfer coverage from another PacifiCare medical plan, this waiting period is reduced by the time you were continuously covered under the prior PacifiCare medical plan.

The following transplants are covered:

- Cornea
- Double lung, for cystic fibrosis only

- Heart
- Heart-lung
- Kidney
- Liver
- Pancreas with kidney
- Single lung.

Skin grafts may be covered under other plan benefits. Bone marrow, hematopoietic stem cells or both from a person other than the covered patient are covered for these diagnoses only:

- Acute lymphocytic or acute nonlymphocytic leukemia
- Advanced or severe myelodysplasia
- Aplastic or chronic myelogenous leukemia
- Hodgkin's lymphoma, limited to stage 3 or 4
- Homozygous beta-thalassemia
- Infantile malignant osteopetrosis
- Neuroblastoma, medulloblastoma or primitive neuroectodurmal tumors stage 3 and 4 in children over age 1
- Non-Hodgkin's lymphoma, limited to stage 3 or 4 of intermediate or high grade
- Severe combined immunodeficiency (not HIV or AIDS)
- Wiskott-Aldrich syndrome.

The covered patient's own bone marrow, hematopoietic stem cells or both are covered for these diagnoses only:

- Acute lymphocytic or acute nonlymphocytic leukemia
- Breast cancer, high-risk stage 2 or 3 only
- Germ cell
- Hodgkin's lymphoma, limited to stage 3 or 4

- Neuroblastoma, medulloblastoma or primitive neuroectodurmal tumors limited to stage 3 or 4
- Non-Hodgkin's lymphoma, limited to stage 3 or 4 of intermediate or high grade.

Transplants (cont'd)

The following services and supplies are covered for the recipient:

- Chemotherapy or radiation therapy to prepare for a bone marrow or stem cell transplant
- Covered medical care starting 3 days before the transplant date and follow-up care (anti-rejection drugs are covered under the prescription drug benefit)
- Donor costs, including removal of an organ, bone marrow or stem cells from a live donor and 10 consecutive days of care; the donor need not be a plan participant and benefits will be coordinated with the donor's group plan as described in "Coordination of Benefits" on page 29
- Harvesting an organ from a cadaver and transporting the organ
- Tissue typing and matching of the recipient's parents, children, brothers or sisters.

The plan does not cover:

- Transplants that are experimental or investigational
- Organ, bone marrow and stem cell transplants or transplants for conditions not listed in this section
- Care related to the transplant and received during the 12-month transplant waiting period; see "Preexisting Conditions" on page 4
- Donor costs when the donor is a plan participant but the recipient is not
- Services for which government funding is available, other than Medicare, Medicaid or CHAMPUS
- Storage costs for any organ or bone marrow

- Tissue typing and matching for anyone other than the family members listed in this section
- Transplants of mechanical or nonhuman organs
- Transportation of any family members for typing and matching
- Anti-rejection medications (covered under prescription drug benefit).

Urgent Care

See page 29 for instructions on what to do if you need urgent care.

This plan covers urgent care, which is treatment for conditions that are not life threatening but may need immediate attention, for example:

- Ear infections
- High fever
- Minor burns.

Generally, urgent care involves an office visit and is paid at the level shown on page 7.

Vision Care

One eye exam every 12 months is covered at 100%.

One pair of eyeglasses or contacts is provided every 24 months as shown below:

Vista Optical	
Lenses	100%
Frames (from selection offered)	100%
Contacts (instead of glasses)	up to $100
All Other Providers	
Lenses and frames	up to $100
Contacts (instead of glasses)	up to $100

EXPENSES NOT COVERED

In addition to the limitations and exclusions described in this booklet, the PacifiCare Medical Plan does not cover:

- Acupressurist or homeopath procedures or those supplied by a Christian Science practitioner/sanitarium or rabbi.
- Charges in excess of UCR rates (see page 29 for a definition).
- Dependent child's pregnancy, including complications or termination.
- Claims not made to PacifiCare within 12 months of the date of service. (If you cannot send in the claim on time due to circumstances beyond your control, PacifiCare will consider the claim for payment if you write and explain the circumstances.)
- Conditions for which the Veterans Administration, federal, state, county or municipal government or any of the armed forces is responsible or provides treatment.
- Conditions resulting from service in the armed forces, declared or undeclared war or voluntary participation in a riot, insurrection or act of terrorism except as required by law.
- Convalescent or custodial care, no matter where it's given or any part of a hospital stay that is primarily convalescent or custodial (this exclusion does not apply to home health and hospice care if part of an approved treatment plan).
- Cosmetic, plastic or reconstructive procedures furnished primarily to improve or change appearance. The following exceptions must be preauthorized by PacifiCare:
  - To correct a congenital anomaly or disease of a child as determined by a plan provider
  - Treatment for an injury within 6 months after the accident causing the injury or as soon as medically feasible

- Reconstructive breast surgery and associated procedures following a mastectomy (regardless of when the mastectomy was performed) and determined in consultation with the patient and attending physician, including:
  - Reconstruction of the breast on which the mastectomy has been performed
  - Surgery and reconstruction of the healthy breast to produce a symmetrical appearance
  - Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas
  - Removal of breast implants
  - Breast reduction when established medical criteria are met.
- Examples of cosmetic expenses that are not covered include:
  - Surgery for sagging skin of the eyelids, face, neck, abdomen, hips or extremities
  - Revision of scars or keloids
  - Breast enlargement or uplift except as stated above
  - Reshaping of the nose (rhinoplasty).

- Court-ordered programs, services or supplies unless considered medically necessary by PacifiCare.

- Dental care, except treatment for accidental injury to the mouth and natural teeth received within 6 months (limited to stabilization services) of the injury. Benefits for dental accidents cover a provider licensed as a denturist for services within the scope of that license that would have been covered if performed by a dentist. Hospital care to extract teeth or for other dental care also is not covered — unless adequate care cannot be provided outside the hospital and an underlying medical condition requires hospitalization.

EXPENSES NOT COVERED (cont'd)

- Educational or self-help training except as covered under Diabetes Care Training on page 15 and under the Healthy Pregnancy Program on page 28.
- Elective or voluntary enhancement procedures, services, supplies and medications including, but not limited to:
  - Weight loss
  - Hair growth
  - Sexual performance
  - Athletic performance
  - Cosmetic purposes
  - Anti-aging and
  - Mental performance.
- Enteral therapy or nutritional supplements.
- Exams, tests or shots required for work, insurance, marriage, adoption, immigration, camp, volunteering, travel, license, certification, registration, sports, school or recreational activities.
- Experimental or investigational procedures as described starting on page 29.
- Foot care, such as:
  - Trimming of nails, corns or calluses unless associated with diabetes
  - Fallen arches or other symptomatic complaints unless associated with a disease affecting lower limbs, such as diabetes
  - Prosthetics and appliances or orthotics connected with or inserted in shoes or impression casting for them, unless associated with diabetes.
- Growth hormones.
- Habilitative therapy for hyperkinetic syndromes of childhood.

- Hearing aids or costs related to their fitting and upkeep.
- Illness or injury from or during work, except if you're a LEOFF I employee and Workers Compensation has been denied.
- Jaw augmentation or reduction (orthognathic surgery), except when medically necessary.
- Methadone, except when used in conjunction with an approved inpatient detoxification program.
- Obesity procedures such as weight control programs, surgery or its complications or wiring of the jaw.
- Orthoptics.
- Procedures that are:
  - Outside the scope of the provider's license, registration or certification
  - Not medically necessary for the diagnosis, treatment or prevention of injury, unless otherwise noted
  - Furnished by a provider not licensed, registered or certified to perform them as required by the state where the provider is practicing
  - Not covered by the provider's malpractice insurance
  - By a provider related to you by blood, marriage, adoption or legal dependency
  - Covered under motor vehicle medical or "no fault" coverage, personal injury protection or similar insurance (this exclusion does not apply to uninsured motorist or underinsured motorist insurance coverage)
  - Received while you are not covered, for which no charge is made or for which a charge is available only because this plan is in effect, except as required by law
  - Obtained without a referral if required from your primary care physician.

EXPENSES NOT COVERED (cont'd)

- Prescription or nonprescription drugs and medicines for outpatient use, including take home drugs from inpatient

stays, other than those covered under the specific prescription drug benefit of this plan. The plan does not cover food items (except PKU formula; see page 25), over-the-counter items or prescription drugs that are not preauthorized (if preauthorization is required).

- Prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy.
- Radial keratotomy or any surgery to change the cornea's refractive character or complications from the surgery.
- Reproductive or sexual disorders or defects (whether or not the consequence of illness, disease or injury) such as:
  - Impotence (except as specifically provided on page 16)
  - Frigidity
  - Fertility or sterility studies
  - Procedures to restore or enhance fertility
  - Artificial insemination or in vitro fertilization
  - Services related to sexual reassignment
  - Reversal of sterilization.
- Temporomandibular joint (TMJ) disorders, as defined on page 29.
- Vision analysis, therapy or training relating to muscular imbalance of the eye.

SPECIAL SITUATIONS

If You Need Emergency Care

Emergency is defined on page 29.

If you need emergency care, follow these steps:

- Dial 911 or go to the nearest hospital emergency room immediately.
- When you arrive, show your identification card.

- If you're admitted, call your plan within 24 hours; otherwise, you may be responsible for all costs incurred before you call. If you're unable to call, have a friend, relative or hospital staff call for you. The plan's telephone number is printed on the back of your identification card.

If you have an emergency as determined by PacifiCare, benefits are paid as described in the "Medical Plan Summary" on page 5. Follow-up care received or coordinated through your primary care provider will be paid as any other care.

If You Need Urgent Care

Sometimes you may need to see a physician for conditions that are not life threatening but need immediate medical attention.

- For urgent care during office hours, call your physician's office for assistance.
- After office hours, call your physician's office and leave your name and number; the physician on call will call you back. Depending on your situation, the physician may provide instructions over the phone, ask you to come into the office or advise you to go to the nearest emergency room.

If You Need Care While Traveling

If you need care while traveling, contact your physician for guidance.

Emergency care and urgent care are covered while you travel. (Refer to the urgent care guidelines above.) All other care is generally not covered unless authorized by your primary care provider.

If Your Family Member Lives Away From Home

Family members who live outside the service area either temporarily or permanently may be eligible for out-of-area benefits. See "If You Live Outside the Service Area" on page 12 for details. If your family members don't qualify for out-of-area benefits, they receive benefits as if they were traveling; see section above for details.

If You Take a Leave of Absence

You must contact Employee Benefits and Well-Being to arrange to continue your medical coverage during a leave of absence. Your coverage will continue (at the cost you currently pay, if any) for the periods established by your collective bargaining agreement.

If You Leave Employment to Perform Military Service

If you leave employment to perform uniformed service (such as service in the military), you may continue medical coverage for up to the shorter of 18 months or the period of your service under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Generally, you must pay the full cost of coverage. To be eligible, you must meet the requirements under USERRA. Contact Employee Benefits and Well-Being for more information. The Veterans Employment and Training Administration is also required to assist you.

If you don't arrange to continue coverage, it will end on the last day of the month you leave employment.

You must give Employee Benefits and Well-Being written notice when you leave employment covered by this plan to perform uniformed service. You must also give Employee Benefits and Well-Being written notice when you return after your uniformed service to employment covered by this plan.

If You Enter Into a Labor Dispute

If your pay is suspended directly or indirectly as a result of strike, lockout or other labor dispute, you may continue medical coverage for up to 6 months for yourself and your eligible family members if you pay the full cost of medical coverage directly to Employee Benefits and Well-Being. At the end of 6 months, you may be eligible for up to 12 more months of coverage under COBRA; see page 29 for details.

If You Are Laid Off

If you are laid off while a participant in this plan, medical coverage for you and your eligible family members may continue for a limited time by paying the full cost of

coverage. See "Continuation of Coverage (COBRA)" on page 29.

If you return to work as an eligible employee within 24 months of the date you were laid off, coverage begins the first of the month following your return. If you return after 24 months, you will be considered a newly hired employee.

If You Die

If you die while a participant in this plan, medical coverage for your eligible family members may continue for a limited time if they pay the full cost of coverage. See page 29.

If You Become Disabled

If you or covered family members participating in this plan are totally disabled and your coverage ends for any reason except plan termination, medical coverage — for the disabling condition only — may be extended for 12 months at no cost to you. You may choose either this medical extension or COBRA coverage. If you elect this extension, you forfeit your right to elect COBRA coverage and your right to convert to an individual policy.

Contact Employee Benefits and Well-Being for more information.

If the plan described in this booklet is terminated, the extension coverage will end on that date. Extension coverage will also end on the date you or your family members:

- Reach any lifetime maximum that may apply
- Are no longer disabled
- Become eligible for benefits under another group policy or
- Reach the end of the 12-month extension.

If You Retire

If you retire before age 65, you may continue your coverage under COBRA as described on page 29. Contact Employee Benefits and Well-Being for eligibility requirements.

FILING A CLAIM

If you're covered by Medicare and Medicare is your primary coverage, you must submit the Medicare Explanation of Benefits form in addition to the claim form and itemized bill.

In most cases, claims will be filed by your provider. If you must file a claim (e.g., if you receive care from a non-network provider), attach PacifiCare Medical Plan's claim form to the itemized bill, which must contain:

- Patient's name
- Provider's tax identification number
- Diagnosis or ICD-9 code
- Date of service
- Itemized charges from the provider for the services received

A separate claim form is necessary for each patient. When filling out the form, be sure to complete all required information, sign the form and attach the itemized bill.

- If treatment is the result of an accident, the date, time, location and brief description of the accident
- Group number (shown on your identification card)
- Employee's name and Social Security number, if the patient is a family member.

For efficient payment, submit all claims within 30 days after the service is provided. PacifiCare will not pay a claim submitted more than 1 year after the date service is received. If you can't meet the 1-year deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

If you receive services from a non-network provider and the claim form indicates full payment has been made, payment for covered expenses will be made directly to you.

When there is no indication the bill has been fully paid, payment will be made to the provider.

Send your medical claims to:

PacifiCare of Washington
PO Box 3005
Hillsbro OR 97123-3008

Mail prescription drug claims to the address shown above. You must use a prescription drug claim form and include:

- Copay (see "Medical Plan Summary" for amount)
- Pharmacy receipt, which shows the cost, drug name, patient name and date the drug was dispensed
- National Drug Code (NDC) number for each drug; the claim cannot be processed without this number found on the prescription label.

Submit mental health care and chemical dependency claims to:

PacifiCare Behavioral Health
23046 Avenida de la Carlota, Seventh Floor
Laguna Hills CA 92653

APPEALING A CLAIM

If your claim is denied in whole or in part, you will be notified in writing of the reason for the denial within 90 days from the date you filed your claim. The notice will include information required if you want to appeal.

You may appeal a denied claim within 60 days of the date you receive the denial notice. This procedure is the only means available to change a benefit decision. To appeal, write to the plan and state the reasons you believe your claim should have been paid. Include any additional documentation to support your claim. You also may submit questions or comments you think are appropriate, and you may review relevant documents.

Normally, you will receive a written decision on your appeal within 60 days of the date the plan receives your request. If special circumstances require a delay, you will be notified of the extension during the 60 days after receipt of your request.

If you have an appeal regarding the denial of benefits for investigational or experimental services, the plan will provide a written explanation within 20 working days of receiving the request for an appeal (unless the plan determines a 20-day extension is warranted due to extenuating circumstances regarding the review process).

RELEASE OF MEDICAL INFORMATION

When you join this plan, you authorize the plan to receive and release information concerning your claims when necessary. In administering benefits, the plan may need to contact your provider or other person, organization or insurance company to obtain or release information such as medical records.

PHYSICAL EXAM

PacifiCare, at their own expense, may have a physician examine the covered patient when an injury or sickness is the basis of a claim. The plan may examine the patient as often as necessary while the claim is pending.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

In accordance with applicable law, the plan provides medical coverage to certain children of yours (called "alternate recipients") if directed by certain court or administrative orders. These include a decree, judgment or order from a state court (including approval of settlement agreement) or administrative order that requires these plans to include a child in your coverage and make any applicable payroll deductions.

A medical child support order is generally considered qualified and enforceable if it specifies:

- Employee name and last known address
- Each alternate recipient's name and address
- A description of the coverage the alternate recipient will receive
- Each plan subject to the order.

When the county receives a medical child support order, we promptly notify you and the alternate recipient that the order has been received and what procedures will be used to determine if the order is qualified. Once the decision is made, we will notify you and the alternate recipient(s) by mail.

COORDINATION OF BENEFITS

In no case will you receive more than 100% of the covered expense.

If you or your family members have additional health care coverage, benefits from the other plan(s) may be considered before benefits are paid under this plan. Additional coverage includes another employer's group benefit plan or other group arrangement — whether insured or self-funded.

The plan that must pay benefits first is considered primary and will pay without regard to benefits payable under other plans. When another plan is primary, PacifiCare will coordinate benefits so you receive maximum coverage (the highest allowable benefit).

If you or your family members are covered under another plan, be sure to keep a copy of your itemized bill and send the bill and Explanation of Benefits to PacifiCare.

If the other plan does not have a coordination of benefits provision, that plan will pay first. If it does, the following rules determine payment:

- The plan covering an individual as an employee will pay first.
- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, the other plan's provisions will apply.)
- If the parents are divorced or legally separated, these rules apply:
    - If the parent with custody (or primary residential placement) has not remarried, the plan of that parent pays before the plan of the parent without custody
    - If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody
    - If the court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility will pay first.

COORDINATION OF BENEFITS (cont'd)

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed will pay first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

PacifiCare has the right to obtain and release data as needed to administer these coordination procedures. For example, if the plan paid too much under the coordination of benefits provision, it has the right to recover the overpayment from you or your provider.

COORDINATION OF BENEFITS WITH MEDICARE

If you continue to work for the county after age 65, you may:

- Continue your medical coverage under the county plan and integrate the county plan with Medicare (the county plan would be primary or pay benefits first)
- When eligible for Medicare, active employees as well as spouses age 65 and over may elect this medical plan or Medicare as primary coverage, under the Tax Equity and Fiscal Responsibility Act of 1982. If Medicare is elected as primary coverage, this medical plan is not available. Contact Employee Benefits and Well-Being for details.

If you have any questions about how your coverage coordinates with Medicare, contact Employee Benefits and Well-Being.

- Discontinue this coverage and enroll in Medicare. (Federal regulations prohibit employer plans from being secondary for active participants.) If you choose this option, your covered family members are eligible for continuation of coverage under COBRA for up to 36 months. See "Continuation of Coverage (COBRA)" on page 29 for details.

WHEN COVERAGE ENDS

Employees

Your medical coverage ends on the last day of the month in which you:

- Are no longer eligible as defined on page 1
- Resign, retire or are terminated.

Your medical coverage also ends on the day:

- This plan terminates
- You die.

Retirees

Retirees are not eligible for this plan.

Family Members

Your family members' medical coverage ends on the last day of the month in which your:

- Coverage ends
- Family member is no longer eligible as defined on page 2.

Your family members' medical coverage also ends on the day:

- This plan terminates
- Your family member dies.

CERTIFICATE OF COVERAGE

When your coverage under this plan ends, you will automatically receive a certificate of health plan coverage. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under this plan. You will need to do this only if the other health plan has a preexisting condition limit.

CONTINUATION OF COVERAGE (COBRA)

To continue coverage, you or your family members must elect COBRA coverage and pay the required premium before the payment deadline.

Continued medical coverage may be available to you and your covered family members under COBRA if coverage ends because of a qualifying event (described below).

Eligibility

You and your covered family members are eligible for up to 18 months of COBRA coverage if you lose coverage because your:

- Employment ends for reasons other than gross misconduct or
- Work hours are reduced to the point where you no longer are eligible for benefits.

If you or your family member who is a qualified beneficiary is determined to be Social Security disabled at the time of one of the above qualifying events (or at any time within the first 60 days of continuation coverage), you and your family members are eligible for up to a total of 29 months of COBRA coverage. Employee Benefits and Well-Being must receive a copy of your Social Security Disability approval letter before the end of the first 18-month continuation period and within 60 days after the date of the Social Security Administration determination.

If a second qualifying event occurs during a continuation period, your family members may continue coverage up to a total of 36 months from the first qualifying event.

Covered family members who are qualified beneficiaries are eligible to continue coverage up to a total of 36 months if coverage ends because of any of these qualifying events:

- Your death
- Your divorce or legal separation
- The loss of dependent-child status
- Your entitlement to Medicare.

How to Apply

If you gain a family member while participating in COBRA, the usual plan rules for enrolling family members will apply. See "Enrolling in the Plan" on page 3 for details.

If you and/or your family member(s) lose medical coverage as a result of termination or reduction of hours, your death or Medicare entitlement Employee Benefits and Well-Being will notify you and/or your family member(s) of your options. If your family member will lose coverage because of divorce, legal separation or a child losing eligibility, you or your family member must notify Employee Benefits and Well-Being within 60 days of the qualifying event or the date coverage ends, if later. Otherwise, your family member's right to continue coverage under COBRA ends.

When your current coverage is scheduled to end, you and your family members will receive details about COBRA. To continue coverage, you must elect COBRA within 60 days after the later of loss of coverage because of a qualifying event or the date of your notice of eligibility to continue coverage.

Paying for COBRA Coverage

Employee Benefits and Well-Being will give you payment amounts and deadlines.

You or your covered family members must make the initial payment within 45 days of the date you elect to continue coverage. Because COBRA coverage is retroactive to the day coverage ended, your initial payment must include all applicable back premiums.

You must keep paying the cost of COBRA coverage on time or it automatically ends.

When COBRA Coverage Ends

COBRA coverage ends when you or your family members:

COBRA coverage also ends if King County terminates the plan and no longer provides medical benefits to active employees.

- First become covered under another group health plan after the date of your COBRA election, unless that plan limits or excludes coverage for a preexisting condition of the individual continuing coverage
- Fail to make the required payments within 30 days of the due date
- First become entitled to Medicare benefits after the date of your COBRA election
- Reach the end of the maximum COBRA coverage period or

- Are no longer disabled as determined by the Social Security Administration.

CONVERTING YOUR COVERAGE

Contact Employee Benefits and Well-Being for conversion forms and more details. You will not receive this information unless you request it.

If you are no longer eligible for the medical coverage described in this booklet, you may convert your coverage. The plan you convert to will differ from the benefits described in this booklet. You must pay premiums, which may be higher than any amounts you currently pay for these benefits.

You will not be able to convert to the individual policy if you:

- Are eligible for any other medical coverage under any other group plan
- Have reached the lifetime maximum benefit.

To apply for a conversion plan, you must complete and return an application form to the plan within 31 days after your medical coverage terminates. Evidence of insurability will not be required.

EXTENSION OF COVERAGE

If this medical plan is canceled, it will continue to cover any participants who are hospital inpatients on the date the plan is terminated. Coverage will end on the date of discharge or when you reach the plan maximums — whichever comes first.

ASSIGNMENT OF BENEFITS

Plan benefits are available to you and your covered family members only. The right to payment under this plan is not subject to attachment or garnishment and the plan will not honor any assignment of benefits to anyone.

In paying for services, the plan may make the payment to you, the provider or another carrier. The plan will also make

payments on behalf of an enrolled child to his or her non-enrolled parent or a state Medicaid agency when required to do so by federal or state law. In these cases, the plan also has the right to make payment jointly.

All payments are subject to applicable federal and state law and regulation. Payments made according to this section will discharge the plan to the extent of the amount paid, so that the plan will not be liable to anyone aggrieved by the choice of payee.

THIRD PARTY CLAIMS

If you receive benefits for any condition or injury for which a third party is liable, the plan may have the right to recover the money paid for benefits. This means the plan is not obligated to pay for services necessary because of an injury or condition for which you may have other recovery rights unless or until you (or someone legally qualified and authorized to act for you) promise in writing to:

- Include those amounts in any claim you or your representative makes for the injury or condition
- Repay the plan those amounts to the extent the proceeds of your recovery for the injury or condition exceed the total loss, prorating any attorneys' fees incurred in the recovery
- Cooperate fully with the plan in asserting plan rights — supplying any and all information and executing any and all documents reasonably needed for that purpose.

Any sums collected by or on behalf of you or your covered family members by legal action, settlement or otherwise — on account of benefits provided under this plan — are payable to the plan only after and to the extent the sums exceed the amount required to fully compensate you for your loss.

RECOVERY OF OVERPAYMENTS

The plan has the right to recover amounts paid that exceed the amount for which the plan is liable. This amount may be recovered from 1 or more of the following (to be determined by the plan): any persons to or for or with respect to whom such payments were made, any other insurers, any service plans or any organizations or other plans. These amounts may be deducted from your future benefits (or your family members' benefits, even if the original payment was not made on that family member's behalf).

The plan's right of recovery includes benefits paid in error due to any false or misleading statements made by you or your family members.

PAYMENT OF BENEFITS

The medical benefits offered in this booklet are funded by the plan, not the county (this is not a self-funded plan). This means the medical plan is financially responsible for claim payments and other plan costs.

TERMINATION AND AMENDMENT OF THE PLAN

The county fully intends to continue plan benefits indefinitely, but also reserves the absolute right to amend or terminate the plan for any reason at any time. If the county terminates the plan, bona fide claims incurred before termination will be paid.

DEFINITIONS

To help you better understand your medical benefits, here's a list of important definitions.

Annual Out-of-Pocket Maximum	The most participants pay toward covered expenses each year.
Approved Alcoholism or Drug Treatment Facility	Any hospital or public or private treatment facility (or unit in the hospital or facility) that treats chemical dependency and operates under the direction and control of or contract with the Department of Social and Health Services. (The approved facility will have ADASTA certification.)
Brand-Name Drugs	Trademark drugs patented for a limited period by a single pharmaceutical company.
Certificate of Coverage	A document that provides evidence of prior health plan coverage. Under the Health Insurance Portability and Accountability Act, when a participant's coverage ends, he or she is entitled to receive a certificate of health plan coverage.
Chemical Dependency	A psychological and/or physical dependence on alcohol or a state-controlled substance. (Nicotine is not state-controlled and is not eligible under the chemical dependency benefit.) The pattern of use must be so frequent or intense that the user loses self-control over the amount and circumstances of use, develops symptoms of tolerance and, if use is reduced or discontinued, shows symptoms of physical and/or psychological withdrawal. The result is that health is substantially impaired or endangered or social or economic function is substantially disrupted.
Coinsurance	The amount you share with the plan toward covered expenses.
Copay	The fixed amount you pay at the time you receive the covered service. Not all covered services require copays; see the "Medical Plan Summary."
Custodial Care	Care primarily to assist the patient in activities of daily living, including inpatient care mainly to support self-care and provide room and board. Examples are helping the patient to walk, get in and out of bed, bathe, dress, eat, prepare special diets or take medication that is normally self-administered.
Dental Care	Care of or related to the mouth, gums, teeth, mouth tissues, upper or lower jaw bones or attached muscle, upper or lower jaw augmentation or reduction procedures, orthodontic appliances, dentures and any care generally recognized as dental. This also includes related supplies, drugs and devices.

Durable Medical Equipment

Mechanical equipment that can stand repeated use and multiple users, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury and is prescribed by a physician.

DEFINITIONS (cont'd)

Emergency

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent person acting reasonably to believe that a health condition exists that requires immediate medical attention. Failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or place the person's health in serious jeopardy.

Experimental and Investigational

Procedures that are not medically necessary, have not been proven effective for the patient's condition or are not generally accepted as a standard of good medical practice. PacifiCare's medical professionals consider a procedure experimental or investigational if it meets any conditions below on the date the procedure is provided or preauthorization is requested, whichever comes first:

- The appropriate government agency has not approved the procedure for the condition as required by law or has approved it only for investigational use.
- Authoritative medical or scientific literature (such as medical journals/textbooks and government or industry reports) shows the procedure is undergoing clinical trials or experts agree studies or clinical trials are needed to determine the maximum dose, toxicity, safety, efficacy or relative efficacy compared to other procedures available for the condition. (Experts are professionals or organizations recognized as proficient in the scientific rationale for a treatment, the clinical care of patients undergoing the treatment or the logical design of clinical research to demonstrate efficacy for new treatments.)
- The provider has not shown proficiency in the procedure, based on experience and satisfactory outcomes in an acceptable number of cases.

Generic Drugs

Medications that are not trademark drugs, but are chemically equivalent to the brand-name drug.

Hospice

A private or public agency or organization with a hospice agency license that administers or provides a coordinated program of supportive care for a dying person.

Hospital

An institution licensed by the state and primarily engaged in diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured or ill persons by or under the supervision of a staff of physicians. The institution also continuously provides 24-hour nursing service by or under the supervision of registered nurses or in any other licensed institution where the plan has an agreement to provide hospital services.

The following are not hospitals: skilled nursing facilities, nursing homes, convalescent homes, custodial homes, health resorts, hospices or places for rest, the aged or to treat pulmonary tuberculosis.

LEOFF I Employees

Firefighters and law enforcement officers who are members of LEOFF Plan I.

Lifetime Maximum

The maximum benefit amount a plan participant may receive under the plan and prior PacifiCare plans in his or her lifetime. This term is not intended to imply coverage is or will be available for anyone's full life.

Manipulative Therapy

Manipulation of the spine or extremities to correct a subluxation (incomplete or partial dislocation) shown by an x-ray. The subluxation identified on the x-ray must be consistent with neuromusculoskeletal symptoms related by the patient, and treatment must be within the limits of a specific documented treatment plan. Services must be provided by a state-licensed chiropractor or osteopath. Chiropractors are restricted by law to manipulation of the spine. Osteopaths are licensed to perform manipulative therapy to all parts of the body.

Medical Group

The providers to which you may be referred by your primary care provider.

Medically Necessary

Health care services, supplies, treatment or settings considered necessary to diagnosis or treat sickness or injury and:

- Consistent with the symptoms, diagnosis and treatment of your condition
- Appropriate within standards of good medical practice

- Not solely for the convenience of the patient, physician or provider

DEFINITIONS (cont'd)

Medically Necessary (cont'd)

- The least costly of available, adequate alternatives (for an inpatient, it also means the item cannot be provided safely on an outpatient basis without adverse effect).

PacifiCare reserves the right to determine whether a service, supply or setting is medically necessary. The fact a physician or other provider has prescribed, ordered, recommended or approved a service, supply, treatment or setting does not, in itself, make it medically necessary.

Mental Condition

A condition classified as such by the Diagnostic and Statistical Manual of Mental Conditions, fourth edition.

Network Provider

A person, group, organization or facility under contract to furnish covered services to plan participants.

Open Enrollment

The annual period when eligible King County Deputy Sheriff employees may join a plan or change plans and add family member coverage.

Physician

A provider licensed by the state in which he/she practices as:

- Doctor of medicine or surgery
- Doctor of osteopathy
- Doctor of podiatry
- Registered nurse
- Chiropractor
- Dentist (DDS or DMD)
- Psychologist (if licensed by the state to practice psychology and in private practice).

Preauthorization

Approval for medical services or supplies, *before* the patient receives them.

Prescription Drug

Any medical substance that, under the Federal Food, Drug and Cosmetic Act (as amended), must be labeled with "Caution: Federal Law prohibits dispensing without a prescription."

Primary Care Provider (PCP)	A provider under contract with the PacifiCare Medical Plan who provides or coordinates care for plan participants who choose him/her.
Primary Hospital	The network hospital with which a primary care provider is affiliated. Primary care providers have agreed to refer patients to this hospital whenever possible.
Prosthesis	An artificial substitute to replace a missing natural body part.
Provider	A person, group, organization or facility that provides medical services, equipment, supplies or drugs. This includes the following providers regulated under Title 18 of the RCW: naturopaths, acupuncturists and massage therapists.
Referral	An approved, prior authorization by a primary care provider.
Respite Care	Time off or a break for someone who is the main caregiver for an aged, ill or disabled adult or child.
Service Area	The geographic area in Washington state where the plan is authorized by the Insurance Commissioner to arrange for covered services through agreements with plan providers.
Skilled Nursing Facility	A facility that provides room and board as well as skilled nursing care 24 hours a day and is accredited as an extended care facility or is Medicare-certified as a skilled nursing facility. It is not a hotel, motel or place for rest or domiciliary care for the aged.
Temporomandibular Joint (TMJ) Disorders	The temporomandibular joint connects the mandible, or jawbone, to the temporal bone of the skull. TMJ disorders include those with 1 or more of the following characteristics: • Pain in the musculature associated with the TMJ • Internal derangements of the TMJ • Arthritic problems with the TMJ • Abnormal range of motion or limited range of motion of the TMJ.

Urgent Care

A condition that is not life threatening but requires immediate medical attention.

Usual, Customary and Reasonable (UCR) Rates

The rates typically charged for comparable medical services provided by health care professionals in a given region with similar training and experience. UCR rates are updated every 6 months to reflect any changes due to inflation or other reasons.

DEFINITIONS (cont'd)

Women's Health Care Services

These include the following health care services:

- Maternity care
- Reproductive health services
- Gynecological care
- General examinations and preventive care as medically appropriate
- Medically appropriate follow-up visits for the above services.

PARTICIPANT BILL OF RIGHTS

If you have questions about your benefits contact your plan as shown in the Directory.

As a plan participant, you have certain rights, as described below.

Dignity and Respect

You have the right to be treated with consideration, dignity and respect. You also have the responsibility to respect the rights, property and environment of all providers and other patients.

You have the right to see your own medical records and to have those records kept private and confidential unless required to settle a claim.

You have these rights regardless of your gender, race, sexual orientation, marital status, culture or economic, educational or religious background.

Knowledge and Information

You also have the right to take an active part in decisions about your care. Once you participate in and agree to a treatment plan, you are responsible for following that plan or telling your physician otherwise.

You have the right — and the responsibility — to know about and understand your health care and your coverage, including:

- Names and titles of all providers involved in your care
- Medical condition and health status
- Services and procedures involved in your treatment plan
- Ongoing health care you need once you're discharged or leave the physician's office
- How the plan works (you will find that information in this booklet)
- Medication prescribed for you — what it is, what it's for, how to take it properly and possible side effects.

Continuous Improvement

You are partners with your plan, your primary care provider and other health care professionals involved in your care.

You have the right to:

- Call or write with any questions or concerns and make suggestions for improving the plan
- Ask your physician to explain or give you more information about any medical advice or prescribed treatment
- Appeal any medical or administrative decisions (see "Appealing a Claim" on page 29).

Plan Participant Accountability and Autonomy

As a partner in your own health care, you have the right to:

- Refuse treatment — as long as you accept responsibility and the consequences of that decision
- Complete an advance directive, such as a living will or durable power of attorney, for health care
- Refuse to take part in any medical research projects
- Be advised of the full range of treatment options (whether covered under this plan or not) and their potential risks, benefits and costs

- Make the final choice among treatment alternatives.

You also are responsible to:

- Show your identification card to your physician, hospital or other provider before you receive care
- Provide your current primary care provider with all previous medical records and give accurate, complete medical information to all physicians or other providers involved in your care

Plan Participant Accountability and Autonomy (cont'd)

If you decide to give someone else the legal power to make decisions about your health care, that person will also have all of these rights and responsibilities.

- Be on time for appointments and let your physician's office know as far in advance as you can if you need to cancel or reschedule
- Follow instructions given by those providing your care
- Send copies of claim statements or other documents if requested
- Let your plan know within 24 hours or as soon as reasonably possible if you receive emergency care or out-of-area urgent care
- Tell your plan and your primary care provider about planned health care, such as a surgery or an inpatient stay
- Pay all required copays when you receive health care.